

In re) Fair Hearing No. 11,468
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Appeal of)

The petitioner appeals the decision by the Department of Social Welfare denying her Medicaid coverage for dentures. The issue is whether dentures for the petitioner constitute treatment for temporomandibular joint syndrome (T.M.J.) within the meaning of the pertinent regulations.

The petitioner is a thirty-four-year-old woman with a history of psychological problems and somatic complaints. The medical record includes the following (uncontroverted) statement from the petitioner's osteopathic physician (D.O.):

[Petitioner] suffers with a TMJ (temporal mandibular joint dysfunction). Each time I treat her I have to stabilize her jaw, so she can maintain relative comfort. However, my treatments alone are not adequate to obtain the medical objective needed, even when I see her at regular six week intervals.

ORDER

The Department's decision is reversed.

REASONS

There is a provision in the "dental services" portion of the regulations that dentures as a "rehabilitative, cosmetic, or elective procedure" are not covered under Medicaid. Medicaid Manual § M 621. However, under the "physician services" section of the regulations, MM § M 619.1 appears the following:

Treatment for temporomandibular joint dysfunction is a covered medical service for recipients of any age. Reimbursement will be made to enrolled providers (M.D., D.M.D., or D.D.S.).

The Board has held that when, as here, an individual can establish through medical evidence that dentures are integral and necessary for the treatment of T.M.J., Medicaid coverage is clearly provided under § M 619.1, supra.¹ See Fair Hearing Nos. 10,379 and 11,207.

In this case, the Department has orally informed the hearing officer that it does not accept the diagnosis of an osteopathic physician as evidence of TMJ. Arguably, section M 619.2, supra, limits Medicaid coverage for the treatment of TMJ to an "M.D., D.M.D., or D.D.S." However, as a general matter, the regulations provide for Medicaid coverage for the "diagnostic services" of either an "MD" or a "D.O." MM § M 610. It seems perverse that the Department would allow payment for a D.O.'s diagnosis, but then would reject that diagnosis out of hand as a matter of evidence.

In fairness to the Department in this case, it must be noted that it agreed to expedite its consideration of the recently-obtained D.O. opinion so that the case would not be delayed past this Board meeting. The Department has not had time to either attempt to explain its position or seek a consultative medical assessment of the petitioner. Nonetheless however, the fact remains that the opinion of the D.O. in this case is entirely incontroverted,² and the Board finds no basis in the regulations not to accept a diagnosis of TMJ by a D.O. Therefore, the Department's decision is reversed.

FOOTNOTES

¹In those cases the Board observed that it would be wasteful and irrational to deny coverage for dentures under § M 619.1, but provide seemingly-open-ended coverage for other treatment of T.M.J. when dentures can reduce or eliminate the need for these other services.

²A statement from the petitioner's treating psychiatrist also offers a diagnosis of TMJ.

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